FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0014290

Facility Name: The Clayberg

Address: 625 E. Monroe, P.O. Box 200 (Number) Cuba (City) 61427 (Zip Code)

County: Fulton

Telephone Number: (309) 785-5012 **Fax #** (309) 785-5376

IDPA ID Number: 370914241001

Date of Initial License for Current Owners: 7/6/69

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	x	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	x	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Gary Brown **Telephone Number:** (309) 785-5012

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/03 to 11/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Gary Brown
(Title) Administrator

Paid Preparer

(Signed) compilation report is attached (Date)
(Print Name and Title) John P. Lehman, Partner
(Firm Name & Address) Clifton Gunderson, LLP, 301 SW Adams, Ste 900, PO Box 1835, Peoria, IL 61656-1835
(Telephone) (309) 671-4500 Fax # (309) 671-4508

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/03 Ending: 11/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 49

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,934	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	49	TOTALS	49	17,934	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	11,515	5,866		17,381	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,515	5,866		17,381	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.92%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 7/6/69

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 11/30/04 Fiscal Year: 11/30/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/03 Ending: 11/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	160,255	6,538	2,888	169,681		169,681		169,681			1
2	Food Purchase		81,723		81,723		81,723	(2,455)	79,268			2
3	Housekeeping	132,193	5,468		137,661		137,661		137,661			3
4	Laundry		9,386	108	9,494		9,494		9,494			4
5	Heat and Other Utilities			50,446	50,446		50,446	(2,313)	48,133			5
6	Maintenance	45,568	22,971	17,223	85,762		85,762		85,762			6
7	Other (specify):*											7
8	**TOTAL General Services**	338,016	126,086	70,665	534,767		534,767	(4,768)	529,999			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	684,941	29,832	7,833	722,606		722,606		722,606			10
10a	Therapy	35,019		8,064	43,083		43,083		43,083			10a
11	Activities	57,046	4,347	1,750	63,143		63,143		63,143			11
12	Social Services	28,044		1,750	29,794		29,794		29,794			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	805,050	34,179	19,397	858,626		858,626		858,626			16
	C. General Administration											
17	Administrative	55,316		1,231	56,547		56,547		56,547			17
18	Directors Fees											18
19	Professional Services			4,150	4,150		4,150		4,150			19
20	Dues, Fees, Subscriptions & Promotions			12,574	12,574		12,574	(5,692)	6,882			20
21	Clerical & General Office Expenses	31,906	6,649	4,158	42,713		42,713	5,094	47,807			21
22	Employee Benefits & Payroll Taxes			362,719	362,719		362,719	49,976	412,695			22
23	Inservice Training & Education			2,048	2,048		2,048		2,048			23
24	Travel and Seminar			1,923	1,923		1,923		1,923			24
25	Other Admin. Staff Transportation			991	991		991		991			25
26	Insurance-Prop.Liab.Malpractice			31,654	31,654		31,654		31,654			26
27	Other (specify):*											27
28	**TOTAL General Administration**	87,222	6,649	421,448	515,319		515,319	49,378	564,697			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,230,288	166,914	511,510	1,908,712		1,908,712	44,610	1,953,322			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number The Clayberg #0014290 Report Period Beginning: 12/1/03 Ending: 11/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			55,930	55,930		55,930		55,930			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			55,930	55,930		55,930		55,930			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		651		651		651		651			39
40	Barber and Beauty Shops			7,913	7,913		7,913		7,913			40
41	Coffee and Gift Shops		4,928		4,928		4,928	(4,841)	87			41
42	Provider Participation Fee			26,879	26,879		26,879		26,879			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		5,579	34,792	40,371		40,371	(4,841)	35,530			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,230,288	172,493	602,232	2,005,013		2,005,013	39,769	2,044,782			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/03 Ending: 11/30/04

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,455)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,313)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,851)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(5,682)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (15,301)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	55,070	see VII	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 55,070		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 39,769		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

The Clayberg

ID# 0014290

Report Period Beginning: 12/1/03

Ending: 11/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	lobbying portion of dues	$ (841)	20	1
2	vending machine costs	(4,841)	41	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(5,682)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/03 Ending: 11/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,455)	0	0	0	0	0	0	0	0	0	0	(2,455)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(2,313)	0	0	0	0	0	0	0	0	0	0	(2,313)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,768)	0	0	0	0	0	0	0	0	0	0	(4,768)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(5,692)	0	0	0	0	0	0	0	0	0	0	(5,692)	20
21	Clerical & General Office Expenses	0	5,094	0	0	0	0	0	0	0	0	0	5,094	21
22	Employee Benefits & Payroll Taxes	0	49,976	0	0	0	0	0	0	0	0	0	49,976	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(5,692)	55,070	0	0	0	0	0	0	0	0	0	49,378	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(10,460)	55,070	0	0	0	0	0	0	0	0	0	44,610	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number The Clayberg **#** 0014290 **Report Period Beginning:** 12/1/03 **Ending:** 11/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(4,841)	0	0	0	0	0	0	0	0	0	0	(4,841)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(4,841)	0	0	0	0	0	0	0	0	0	0	(4,841)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(15,301)	55,070	0	0	0	0	0	0	0	0	0	39,769	45

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/03 Ending: 11/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Fulton County	100	none		Fulton County	Lewistown	county govt

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	payroll and accounts payable	$	Fulton County	100.00%	$ 5,094	$ 5,094	1
2	V	22	health insurance	137,488	Fulton County	100.00%	187,464	49,976	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 137,488			$ 192,558	$ * 55,070	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/03 Ending: 11/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/03 Ending: 11/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/03 Ending: 11/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	none						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/03 Ending: 11/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	none	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	none	2
3. Under or (over) accrual (line 2 minus line 1).	$	none	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	none	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	none	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	none	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	none	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Clayberg COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0014290

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/03 Ending: 11/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,920 B. General Construction Type: Exterior brick Frame concrete block & steel Number of Stories one

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	building site	217,800	1969	$ 5,000	1
2					2
3	TOTALS	217,800		$ 5,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/03 Ending: 11/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	49		1969	1969	$ 271,336	$ 6,784	40	$ 6,784	$	$ 237,771	4
5				1977	6,286		20			6,286	5
6				1978	8,009		20			8,009	6
7				1979	52,592	1,737	30	1,737		45,646	7
8				1980	23,875		10			23,875	8
	Improvement Type**										
9	windows and plaster repair			1981	17,092		3 to 10			17,092	9
10	fire alarm and sprinkler system, front porch and patio			1982	8,432		5 to 20			8,432	10
11	office remodeling			1983	3,272		5 to 10			3,272	11
12	roof			1984	2,005		10			2,005	12
13	canvas, floors, sewer, box, sign, door			1985	17,304	322	15 to 25	322		15,573	13
14	roof and shutters			1986	3,066	16	15 to 25	16		2,971	14
15	shed, roof and floor tile			1987	17,275	259	15 to 25	259		16,385	15
16	heating and cooling system			1988	9,166	458	20	458		7,409	16
17	IDPA adjustment			1989	1,806	90	20	90		722	17
18	new shed			1990	8,284	552	15	552		7,869	18
19	new shed			1991	10,876	725	15	725		9,849	19
20	drain			1992	743	49	15	49		628	20
21	roof and greenhouse			1993	62,282	4,152	15	4,152		49,486	21
22	road repair			1994	13,496		5			13,496	22
23	storage building addition			1994	4,265	213	20	213		1,937	23
24	storage building addition			1996	12,141	607	20	607		5,244	24
25	laundry facility			1997	15,274	764	20	764		5,823	25
26	carpet			2000	1,734	174	10	174		838	26
27	heating and cooling system			2000	4,564	228	20	228		951	27
28	walk path			2001	4,177	279	15	279		882	28
29	aviary			2002	4,740	316	15	316		764	29
30	walk path			2002	1,357	90	15	90		219	30
31	flooring			2004	636	47	10	47		47	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/03 Ending: 11/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 586,085	$ 17,862		$ 17,862	$	$ 493,481	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/03 Ending: 11/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 245,233	$ 22,096	$ 22,096	$	5 to 20	$ 151,348	71
72	Current Year Purchases	25,358	1,182	1,182		5 to 10	1,182	72
73	Fully Depreciated Assets	164,865	1,498	1,498		3 to 15	164,865	73
74								74
75	TOTALS	$ 435,456	$ 24,776	$ 24,776	$		$ 317,395	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	pickup,delivery and plowing	2001 Ford truck with plow	2001	$ 23,817	$ 4,764	$ 4,764	$		$ 16,672	76
77	patient transportation	2000 Chevy bus	2000	42,641	8,528	8,528			36,955	77
78										78
79										79
80	TOTALS			$ 66,458	$ 13,292	$ 13,292	$		$ 53,627	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,092,999	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 55,930	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 55,930	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 864,503	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/03 Ending: 11/30/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/03 Ending: 11/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

no nurse aides were trained during this report period because the facility hired only aides who were already certified

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		15	609		15	609	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		55	3,855		55	3,855	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): prescription drugs	39-2					651		651	13
14	TOTAL			$	70	$ 4,464	$ 651	70	$ 5,115	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number The Clayberg **#** 0014290 **Report Period Beginning:** 12/1/03 **Ending:** 11/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 11/30/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 552,925	$	1
2	Cash-Patient Deposits	1,195		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	249,602		3
4	Supply Inventory (priced at cost)	5,656		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 809,378	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	150,000		12
13	Land	5,000		13
14	Buildings, at Historical Cost	586,085		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	501,914		16
17	Accumulated Depreciation (book methods)	(864,503)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 378,496	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,187,874	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 25,485	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,195		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,892		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to State of Illinois	120,751		36
37	accrued compensated absences	65,358		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 277,681	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	accrued compensated absences	29,638		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 29,638	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 307,319	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 880,555	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,187,874	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/03 Ending: 11/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 905,445	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 905,445	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(281,288)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (281,288)	17
	B. Transfers (Itemize):		
18	**transfer in from county IMRF fund**	79,774	18
19	**transfer in from county FICA fund**	94,117	19
20	**transfer in from county general fund**	1,231	20
21	**transfer in from county insurance fund**	69,650	21
22	**transfer in from county unemployment insurance fund**	11,626	22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 256,398	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 880,555	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/03 Ending: 11/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,671,585	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,671,585	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	4,841	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,455	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 7,296	23
	D. Non-Operating Revenue		
24	Contributions	28,873	24
25	Interest and Other Investment Income***	15,921	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 44,794	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	miscellaneous	50	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 50	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,723,725	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	534,767	31
32	Health Care	858,626	32
33	General Administration	515,319	33
	B. Capital Expense		
34	Ownership	55,930	34
	C. Ancillary Expense		
35	Special Cost Centers	13,492	35
36	Provider Participation Fee	26,879	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,005,013	40
41	**Income before Income Taxes (line 30 minus line 40)****	(281,288)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (281,288)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/03 Ending: 11/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,758	1,914	$ 43,189	$ 22.56	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,678	3,880	82,404	21.24	3
4	Licensed Practical Nurses	7,568	8,297	155,078	18.69	4
5	Nurse Aides & Orderlies	36,363	40,278	364,520	9.05	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,815	3,509	35,019	9.98	8
9	Activity Director	1,652	2,102	25,517	12.14	9
10	Activity Assistants	3,319	3,836	31,529	8.22	10
11	Social Service Workers	1,869	2,200	28,044	12.75	11
12	Dietician					12
13	Food Service Supervisor	1,720	2,355	44,164	18.75	13
14	Head Cook	7,985	8,576	79,240	9.24	14
15	Cook Helpers/Assistants	3,757	4,478	36,851	8.23	15
16	Dishwashers					16
17	Maintenance Workers	2,999	3,552	45,568	12.83	17
18	Housekeepers	13,422	14,971	132,193	8.83	18
19	Laundry					19
20	Administrator	1,855	1,959	55,316	28.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,681	2,106	31,906	15.15	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) care plan coordina	1,713	2,077	39,750	19.14	33
34	TOTAL (lines 1 - 33)	94,154	106,090	$ 1,230,288 *	$ 11.60	34

SEE ACCOUNTANTS' COMPILATION REPORT

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 2,888	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	600	10-3	39
40	Physical Therapy Consultant	84	3,600	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	1,500	11-3	44
45	Social Service Consultant	36	1,500	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	300	$ 10,088		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	96	$ 2,443	10-3	50
51	Licensed Practical Nurses	90	1,885	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	186	$ 4,328		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/03 Ending: 11/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gary Brown	administrator	0	$ 49,772
Marty Jones	interim administrator	0	5,544
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 55,316

B. Administrative - Other

Description	Amount
health committee of County Board expenses	$ 1,231
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,231

C. Professional Services

Vendor/Payee	Type	Amount
Clifton Gunderson, LLP	CPA	$ 3,100
Claudon,Kost,Barnhart,Beal	legal	1,050
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 4,150

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 38,096
Unemployment Compensation Insurance	11,626
FICA Taxes	94,117
Employee Health Insurance	187,464
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	79,774
employee physicals	1,618
TOTAL (agree to Schedule V, line 22, col.8)	$ 412,695

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	588
Health Care Worker Background Check	294
(Indicate # of checks performed 23)	
dues and subscriptions	6,841
less lobbying portion	(841)
advertising	4,851
Less: Public Relations Expense	( )
Non-allowable advertising	(4,851)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,882

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
mileage	720
hotel	727
meal	476
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,923

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/03 Ending: 11/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/03 Ending: 11/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **IHCA 2645; CNHA 460; INHA 200**

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,606** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **26,879**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **2,455**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Clifton Gunderson, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **no** If no, please explain. **report will be issued in May**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.